Leicestershire County Care Limited

Lenthall House

Inspection report

Lenthall Square
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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Requires improvement
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 20 October 2015 and was unannounced. We returned on 27 October 2015 and this was announced.

The service provides accommodation for up to 40 people. At the time of our inspection there were 35 people using the service. It provides care and support to people with needs associated with age, physical disability and people living with dementia. Accommodation is on the ground and first floor, which is accessible using the stairs or the lift. People have their own bedrooms and use of communal areas and garden.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with and relatives were satisfied with the care and support provided. Some people raised concerns about staffing levels but all said that they felt people were safe. People also said that staff understood their individual needs and wishes.

We found most staff were caring, kind and compassionate in their approach. They understood people's individual needs and treated people with dignity and respect. People we spoke with and relatives told us that they were involved in discussions and decisions about their care and treatment. People said they knew how to make a complaint and they would feel confident to do so if required.

Staff received appropriate training and development opportunities to review and develop their practice. Staff recruitment procedures were robust and ensured that appropriate checks were carried out before staff started work.

Staffing levels were based upon people's dependency needs. The provider took appropriate action when people's needs had changed to ensure needs were met. However, concerns were raised by visitors that staff did not appear to have sufficient time to spend with people.

Staff were aware of how to protect people from avoidable harm and were aware of safeguarding procedures. This meant that any allegations of abuse were reported and referred to the appropriate authority.

People had been asked for their consent to care and treatment and their wishes and decisions respected. The provider adhered to the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2008.

Medicines were safely stored and people received their regular medicines as prescribed. We found gaps in recording how creams were administered and staff did not always observe people taking their medicine when it was given covertly in a drink.

People were supported to access additional healthcare professionals whenever they needed to and their advice and guidance had been included into people's plans of care. People's nutritional and dietary requirements had been assessed and a nutritionally balanced diet was provided. However people had to wait a long time before being served their midday meal.

There were systems in place to assess and monitor the quality of the service. This included gathering the views and opinions of people who used the service. People's complaints and issues of concern had been responded to promptly and appropriately. The provider worked closely with both CQC and the local authority to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People raised concerns about staffing levels being insufficient to meet everyone's needs.

Medicines were not always managed correctly in particular creams and covert medicines. People had risk assessments in place that made sure people received safe and appropriate care.

The provider had procedures for protecting people from harm.

Requires improvement

Is the service effective?
The service was effective

People were supported to access healthcare services. Plans of care to meet people's identified needs were comprehensive. The provider sought appropriate support and guidance from healthcare professionals when required.

People said that the food was good and they had sufficient to eat and drink. The menu provided a balanced diet and was based on people's needs and preferences.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards was being met.

Good

Is the service caring?
The service was not consistently caring.

We saw examples of staff being kind and compassionate, but we also saw examples of staff not as supportive as they could be.

People's privacy and dignity was respected and staff had a good understanding of people's needs.

Requires improvement

Is the service responsive?
The service was responsive

Staff understood people's personal preferences and offered individual care.

The provider had a complaints procedure that was accessible for people.

Good

Summary of findings

Is the service well-led?

Good

The service was well led.

People felt the new manager had made improvements to the service that had resulted in them feeling better supported. Staff felt able to raise any issues, concerns.

The provider had systems in place to monitor the quality and safety of the service.

Lenthall House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 20 October 2015 and was unannounced we returned on 27 October 2015 and this was announced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had expertise in understanding a service for people living with dementia.

Before our inspection we reviewed information about the service. This included information we received by way of statutory notifications from the service about events such as incidents and deaths that had occurred since our last inspection. We reviewed the action plan implemented by the provider after our last inspection. We also reviewed Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted commissioners (who fund the care for some people) of the service for their views.

During the inspection we spoke with 10 people who used the service, five staff members and six visitors as well as two visiting health care professionals. We spoke with the area quality manager and the manager.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care plans, four staff files and records associated with the management and running of the service. This included policies and procedures and records associated with quality assurance processes.

Requires improvement

Is the service safe?

Our findings

People we spoke with gave us mixed views about staffing levels. One person told us, "I sometimes have to wait for an hour when I need the commode and I'm in pain then". Another person said "Staff are very good but so busy they need more staff especially in the evening, they rush around." Other people told us, "I've got a bell but I don't need to use it". Relatives also said they had concerns about staffing levels and said there was not always staff around in the communal areas to support people. One comment we received from a relative was, "Call bells are answered ok but there is not enough staff. They need more, there are not enough staff to be able to sit and talk to people and give them time"

A visitor did express concern about the lack of staff and drinks provided for their relative. We discussed this with the registered manager who said they were aware of the need to ensure that people should have regular drinks and had made jugs of juice available in the lounge for people to have during the day. The registered manager told us they would remind staff to encourage people to drink. We noted on the second day of our inspection that more people had drinks next to them than on the first day of our visit and staff were prompting people to drink.

Some staff told us that they felt people's needs were generally being met and that people were safe. However, they were aware that if staff called in sick they could be short staffed and they then found it difficult to monitor people at all times. Also due to some people's dependency needs they sometimes found staffing levels meant they could not spend the time they wanted to with people and had to rush. This was a concern for them.

We saw there were a high number of people with complex needs and there were times when there were no staff visible in the communal areas. Some people were living with dementia and required close observation to meet their needs and manage their safety. We discussed this with the registered manager who showed us how staffing levels were established and that they had recently recruited more staff. We were shown how they had carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels. During our inspection we spoke with a visiting district nurse who also raised concerns about the complex needs of some people who used the service and the staffing levels. Both the registered manager and quality area manager said they would look at staffing levels again to ensure they were deploying staff in the most effective way.

When we asked people whether they felt safe at Lenthall House they told us. "I'm afraid of falls but I haven't had any accidents here, the staff are here to help me so I feel safe." Another person said, "I've not had any accidents so I feel very safe". A visitor told us that despite their relative falling they still felt their relative was safe and well cared for.

Care staff we spoke with understood their responsibilities to protect people from abuse and avoidable harm without restricting their independence. Staff also told us about the whistleblowing policy in place and that they knew how to raise their concerns if they needed to. Staff training records confirmed that staff were due to attend safeguarding training. We were aware that the provider had reported safeguarding concerns to the local authority and us. The local authority has the lead role for investigating safeguarding incidents. We were aware that the provider was working with the local authority with some on-going investigations.

People we spoke with told us they felt involved in discussion and decisions about managing known risks. Risks were assessed and management plans were put in place where risks were identified. We saw that risk plans had been completed for things such as falls, moving and handling and skin care. For example, a person who had been assessed at high risk of falls had a sensor mat by their bed to alert staff when they were mobile.

Staff maintained records of all accidents and incidents. We saw these were audited by the registered manager on a regular basis. We looked at the reports for 2015. This showed that all incidents had been reviewed and action had been taken to reduce further risks. This showed the provider had reviewed and analysed accidents and incidents to see if any changes or action should be taken to prevent future occurrences. We also noted that the number of falls had reduced in the last audit. This showed that the actions the provider had put in place were supporting people to be safe.

Fire safety procedures and checks were also in place. This included safety checks on equipment and the premises. We saw that following the local authority's contract visit improvements had been made to the environment such as

Requires improvement

Is the service safe?

covering exposed hot pipes leading to sinks in people's bedrooms to reduce the risk of burns. The registered manager also told us that the carpet in the communal area had recently been professionally cleaned but as they were unhappy with how it looked a new carpet was to be fitted.

People told us that they received their medicines safely. One person told us "I get my tablets four times a day". We looked at the management of medicines including the medicine administration records for people who used the service. We saw that a senior member of staff administered medicines to people. It was sometimes rushed and staff did not always ensure that the person had taken their medicine. For example we saw that where a person needed their medicine crushed in a drink this was given to the person but staff did not observe them drinking it. This meant that the person may not have taken their medicines.

We were told that the GP had authorised the use of covert medication for a person. We asked what guidance had been sought around the use of covert medication and how it could be prepared for example is it acceptable to be put in hot drinks. The service had not sought guidance. We suggested they contacted the pharmacy.

We saw that protocols were in place where people needed medicines as required (PRN) such as pain relief. However these needed greater clarity. For example a care plan stated that a person should be given Lorazapam prior to personal care. It was not clear on their PRN protocol when it should be given. We brought this to the registered manager's attention who made arrangements for protocols to be improved.

We were told that where people needed creams there were separate medicines administration records, as well as a body map to aid staff to know where the cream should be applied. We saw that there were 23 residents who required creams. However only five had body maps in place and of these two were not completed. We also observed gaps in the medicines administration records where creams should have been administered. On the 19/10/2015 we found that on 14 occasions creams had not been signed for as given. We saw that creams were stored in people's bedrooms. They were not locked away. This meant they were not safely stored and could place people at risk.

During the morning there were maintenance people carrying out remedial work in the lounge area. This was quite loud and at one point a fitting cracked and a small amount of light debris fell from the ceiling. This took place in front of the dining room door as people were being prompted to go for lunch. This made it difficult for some people to negotiate round the maintenance men, particularly if they used walking frames. Staff appeared to be unaware that this had created a problem and presented a risk to people.

Good

Is the service effective?

Our findings

People we spoke with told us that they thought staff had the skills they needed to care for them. One person told us, "The care is good they are fantastic especially the men there are three of them." Another person said, "They go on a lot of courses so I think they must know what they are doing." A visitor said, "They seem to know what they are doing, I am happy with the care my [relative] receives, I couldn't fault it. Another visitor commented, "The staff who have been here a long time understand [person's name] but it is not quite the same with new staff."

Staff told us that they had received an induction when they commenced work at the service and this included training and shadowing of more experienced staff. We saw an example of completed and planned induction that confirmed what we were told. We were also told us staff felt well supported through training and supervision provided by seniors and the registered manager. They also told us that the training they had was helpful because it equipped them to understand the needs for people they supported. One staff member said they had recently done a lot of training, which included dementia awareness and supporting people with diabetes.

Some staff engaged well with people and were able to support people to express themselves about their own needs. We saw staff communicate with a person that followed the guidance in that person's care plan. This meant the person was able to understand what the member of staff wanted them to do and did not become anxious as a result. We saw staff ask a person whose first language was not English if they needed any pain relief. We asked the staff member how they knew if the person understood the request. We were told that although the person did not speak English they communicated using sign language. Staff had a number of basic questions written in the person's language they could use to ensure they could communicate at a very basic level. They also told us that the person's relative helped with communication.

During the course of the inspection we saw a visitor talking to the person, this visitor was in fact a kitchen assistant who had come in early before their shift to be able to talk with the person. The staff member said that although they did not speak the person's first language, they both could speak Polish. Therefore they were able to communicate. We brought this to the registered manager's attention as something positive that could be included in the person's care plan. The registered manager confirmed they would look at this further.

We saw that staff asked people for their views before they provided any type of care intervention. People's plans of care instructed staff to always ask for the person's consent every time they were supporting with personal care. A staff member said, "When you get to know people you know what they like and they don't like, but anyway you ask them what they want."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. The registered manager demonstrated a good understanding of MCA and DoLS, and staff told us they had received some training in this area to help them understand what they needed to do.

Procedures for the administration of medicines to people who lacked capacity to make an informed decision were followed. We spoke with a visiting health care professional who told us that staff would discuss people's needs around giving covert medicines (where people have their medicines concealed in food or drink) and this was only ever done in the best interest of people, written guidance was always given.

We saw further examples where people's mental capacity to consent to their care and treatment had been considered and best interest decisions had been made. For example for one person who had difficulty knowing what the midday meal was, staff had made up two meals and showed them for the person to choose from the two plates. This enabled the person to be involved in making the decision about what they ate.

People told us they received sufficient to eat and drink and that the menu provided choices. A relative told us, "My [person using the service] was underweight when they arrived here but they have put two stone on since they have been here."

Good

Is the service effective?

We observed people as they received their lunchtime meal. The food was nicely presented, was of good portion size and looked appetising. People were offered support and helped by staff to cut up their food and where people needed help to eat their meal this was done discreetly. We saw people were offered drinks and snacks during the day. People's food and fluid intake was assessed and plans of care advised staff of people's needs to keep them well.

We spoke with the cook who told us the main hot meal was at lunch time. In the evening there was a choice of sandwiches, salads, soups, cheese on toast or other hot snacks. People were offered choices in the morning for what they wanted for lunch. The cook recognised that some may have forgotten or changed their minds, so they prepared extra of both options.

People told us that they were able to see a doctor or other healthcare professional when they needed to. One person said, "I still see the physio and last week the district nurse came and did a Doppler examination on my legs as they were swelling a lot. I'm waiting for some elastic stockings and a new three wheel walking frame now." Another person told us they had been poorly one night and the staff had been very attentive. They said, "I can see the GP weekly if I need to." One visitor told us, "My [person using the service] can see a doctor when they need to." Another visitor said, "I'm concerned about the lack of fluids and [person using the service] has had pneumonia three times in the last two years, they have to take constant antibiotics. We are involved with the care plan we can arrange for them to be seen by the GP as required, they come every Tuesday."

The local surgery arranged for a doctor to visit the service every week and staff will arrange for people to see the doctor if they need to.Staff were attentive to changes in people's health and reported these to the registered manager or a senior care worker who contacted the appropriate health professional.

Requires improvement

Is the service caring?

Our findings

People using the service spoke to us in complimentary terms about the staff. We received comments such as, "The staff look after me very well the staff are fantastic especially the men they're very good and I don't mind the male staff caring for me I know I could say if I wasn't happy." And "The staff are all very kind" as well as "The staff all seem very nice." However one person told us, "Not all the staff are kind the male night staff member [name of staff given] makes me say please all the time." We brought this to the registered manager's attention who said they would investigate this further. A visitor told us, "My family visit regularly, at least twice a week and the staff are great. We have no concerns." Another person said that staff were "always very approachable and willing to listen."

Staff we spoke with demonstrated that they understood people's needs and preferences. They told us this helped them to develop a caring relationship with people. We saw that some staff inter-acted with people in a way that demonstrated a caring approach which reflected what people told us about staff. For example, we observed a member of staff speak to a person who was cared for in bed. They asked if they were comfortable and then supported the person to find a more comfortable position all the time explaining what they were doing. They then ensured the person had a drink before leaving them to rest.

However some staff were less skilled than others. For example we saw in the upstairs lounge where there was a small group of people with two members of staff. People were all sitting quietly or sleeping and the staff were sitting talking to each other at the table and the TV was on. One person asked, "What are we going to do now?" A member of staff replied quite abruptly, "I don't know we're just going to relax." Then the member of staff began to use photographs to try to engage people in conversation and stimulate memories. People did not engage and the activity did not really have any meaningful interaction.

We did note that on the first day of our inspection staff were very busy and were unable to spend much time talking with people. The registered manager had told us that the activities person was on annual leave so the usual organised activities were not taking place. They went on to say that staff did try to do some things with people if they had time. On the second day of our visit we saw a staff member sitting with people reading a newspaper together and talking about it.

We found the meal time experience for people was unhurried, relaxed and calm. Where people required assistance and prompts with their meals staff were attentive to people's needs. Staff sat by people when they were supporting them to eat. We also saw a staff member fit a plate guard to a person's plate but this was when they had almost finished their meal and spilt quite a lot of it. We did note it took a long time for people to receive their meal. In some instances people were sat at the table in excess of twenty five minutes before being served.

Staff gave us examples of how they protected people's privacy and dignity these included, knocking on doors, covering people when delivering personal care. Our observations of staff supporting people with their mobility needs showed that people's dignity was respected. Staff provided reassurance and explanation to the person they were supporting. However we saw many women were not wearing tights, stockings or socks, which potentially could compromise their dignity. Both staff and some visitors did comment that as the bedrooms were not ensuite this could compromise people's dignity as they would need to use a commode.

People's care plans provided staff with guidance of how to include people and their relatives or representatives as fully as possible. This demonstrated that staff were aware of their responsibility to support people in making lifestyle choices.

Relatives told us that there were no restrictions on when they visited and that staff were welcoming, friendly and approachable. People had a choice of where they could meet with their visitors that promoted independence, confidentiality and privacy.

Good

Is the service responsive?

Our findings

People told us they felt able to speak with staff or the registered manager to share their views. One person said, "Yes I can make suggestions and they listen. I like to watch the news on TV and read the Harborough Mail on Thursday they get it in I like reading." Another person told us, "I'm happy to have the male carers but I could say if I wasn't."

Before people moved to the service their needs were assessed to ensure the service could meet people's individual needs. Not all people we spoke with could recall their involvement in the development of their plans of care. A relative said they had contributed to the assessment and planning of their relatives care. They also said that when their relative's needs had changed they had been involved in reviewing the care plan.

People's care records contained details of people's likes, dislikes, preferences, history and preferred diet. Additionally, people's preference to male or female staff for personal care was recorded. This information provided staff with the required knowledge to provide care and treatment that was personalised to meet people's individual needs. The registered manager had been rewriting every person's care plan to make it more focussed on the individual and personalised. For example, after we read one person's plan we were able to identify who this person was from the detailed dscription of their behaviours. We also saw that staff followed suggested prompts written in the plan on how best to support the person. This ensured that their individual needs were being met.

People told us that their religious or spiritual needs had been considered and respected. One person said, "The minister visits here monthly and he sings and plays the guitar for us it's lovely."

Staff we spoke with showed an awareness and good understanding of people's routines and preferences including what was important to them. We were told that staff had a handover at the start of each shift to share important information about people's needs with colleagues. For example, where someone had seen the GP during the day staff shared what the outcome was and what staff coming on shift should monitor.

People told us that staff tried to provide personalised care. A person told us, "The activity co-ordinator is good and tries to find things for us to do and asks for ideas." People also said they were able to choose how they spent their day. We were told, "I can go out if I want to." Another person said, "I go out with my family but I do go out on my own. I like to go into town for a stroll and then I can get a taxi back. I go out to the Baptist church and then to the café." A relative did report that, "We are asked about [person who used the service] care needs but I've spoken with the registered manager about the thickener for the drinks but they're still not always doing it."

People who used the service and their relatives told us that although there were some activities often there was no one to talk to. One person said, "I would like more people to talk." A visitor commented, "People with dementia take priority and so there are no staff to talk to for the people who don't have dementia."

Whilst people's interests and hobbies had been identified and recorded, during our inspection we did not see people being offered activities to participate in. People were seen to watch television in the communal lounges or they remained in their room. Whilst one communal lounge upstairs had two staff trying to involve people in some activities, these were limited. The registered manager told us that the provider employed two activity coordinators who were unavailable at time of our inspection.

We saw that some of the toilets had been labelled in a different language. The registered manager told us this was to assist the person who did not speak English to be able to locate the toilets close to the lounge and their bedroom. This assisted the person to orientate themselves around the service.

People told us they knew who to complain to if they had concerns. The service had a complaints procedure that was available to both people who used the service and visitors. There had been six complaints received in the last twelve months. The compliants had been investigated and there were detailed notes as to the registered manager's investigation and response. This showed the provider had a system to record, investigate and respond to complaints.

Good

Is the service well-led?

Our findings

People who used the service told us they felt listened to by the registered manager. One person commented, “I feel the manager is very good. She likes to try to get things done and listens and is always trying to do her best. I can ask her to help.” Another person said, “The manager is very nice, she rushes about and has a lot to do but I do like her very much she’s very kind.” A relative said, “The new manager is brilliant and much better than the previous two. I can talk to her and ask her things, she is here most of the time.” We also received other positive comments such as, “we have a lot of trust in the manager.” “The manager is very approachable.” And, “The manager tries hard to improve things, I feel it is going in the right direction.”

People we spoke with could not recall there being a residents meeting for some time. The registered manager told us they were planning to hold a meeting soon but had been focussed on other aspects of improving the service.

The registered manager promoted a culture that was open and encouraged staff to raise concerns about the service. Staff told us they were confident that any concerns they raised would be taken seriously. Staff members commented that they found the registered manager supportive.

People’s feedback about the service had been sought by means of a satisfaction survey, however these were not dated so it was difficult to determine which year they referred to. We discussed this with the registered manager and the compliance care and standards manager who both said they would ensure this was included in future. Surveys are analysed by the compliance care and standards manager to look at trends and help create improvement plans for the service.

The provider visits the service regularly to ensure that standards are being maintained. We were told by the local authority that communication between the service and the local authority had improved significantly in the last few months. This meant the local authority had a better understanding of what was happening in the service.

There were robust systems in place for assessing and monitoring of the service that operated on two levels. Firstly, the registered manager carried out scheduled checks of aspects of the service and reported findings to an area manager. The compliance care and standards manager carried out regular inspections of the service to verify the registered manager’s reports of their checks. During our inspection the compliance care and standards manager was present and had a good knowledge of the home and where improvements had been made or were panned to be made.

Audits included ensuring that the service was safe, such as regular servicing of equipment being used and of the building itself. We also saw that the call bell system was monitored to check how long call bells took to be answered. This meant that the registered manager had the information to show how long people needed to wait before a member of staff assisted them.

Registered persons are required to notify CQC of certain changes, events or incidents at the service. Records showed that since our last inspection the provider had notified CQC of changes, events or incidents as required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.